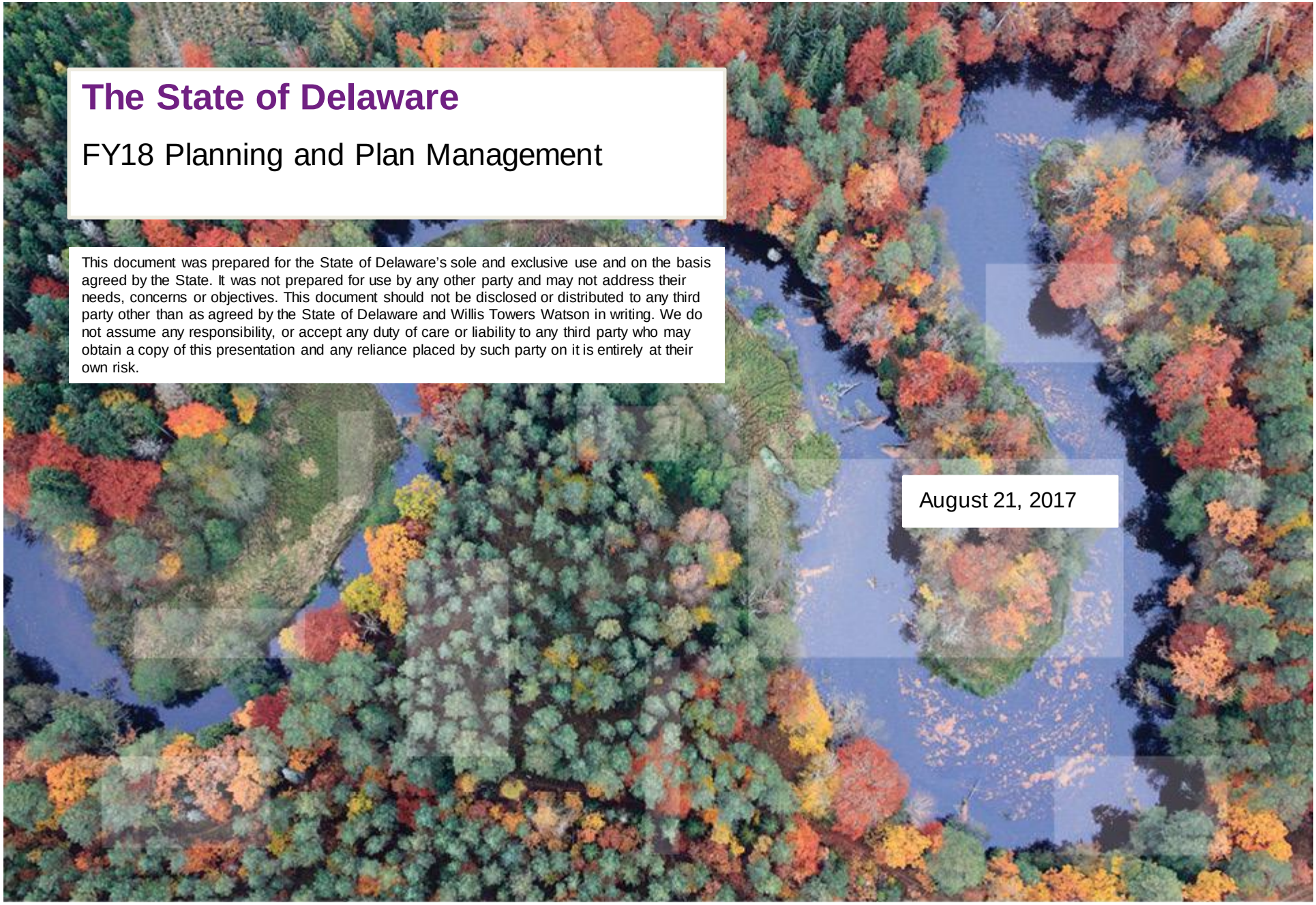

# The State of Delaware

## FY18 Planning and Plan Management

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August 21, 2017



Willis Towers Watson

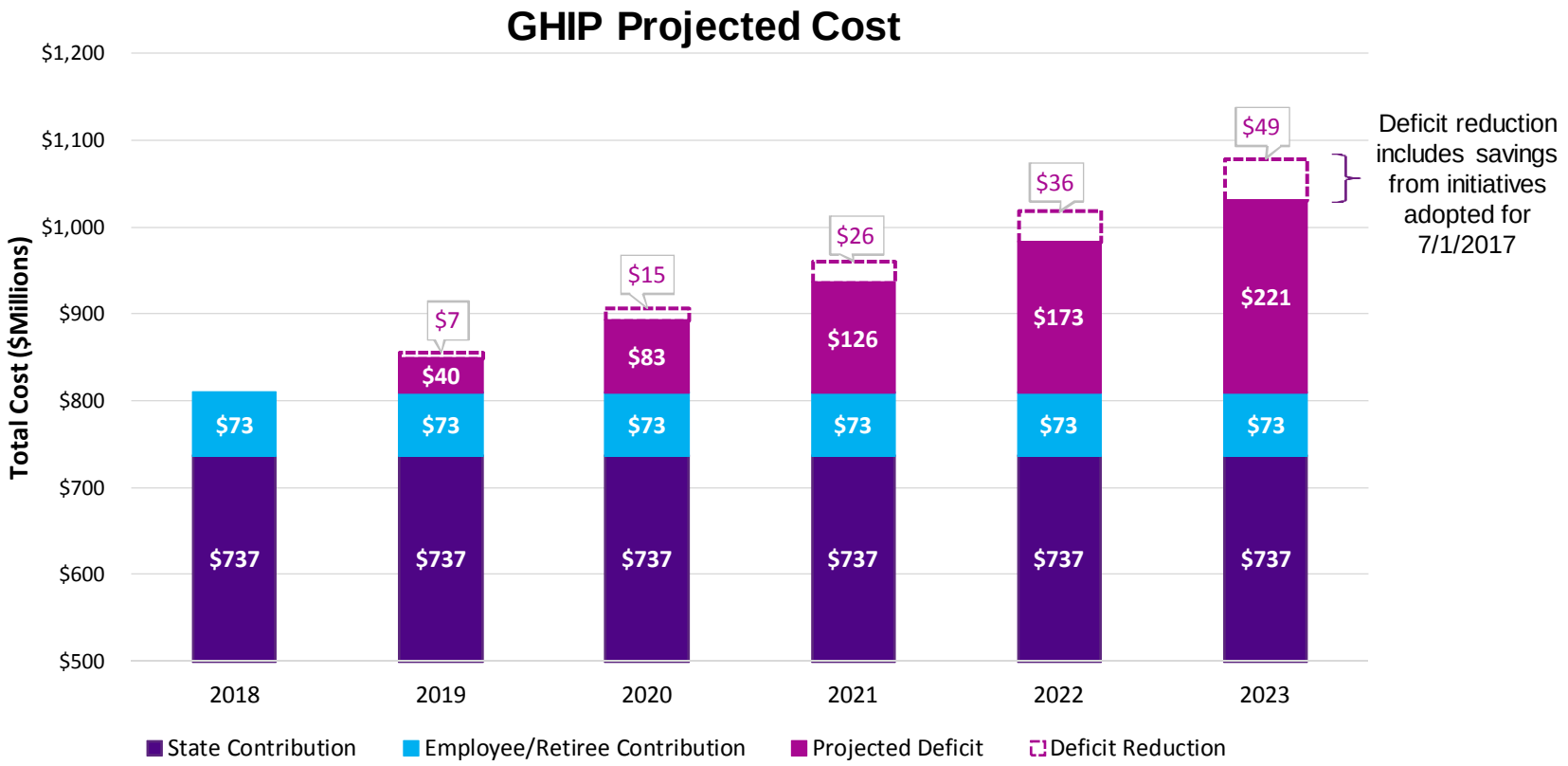
# Contents

- Long Term Health Care Cost Projections for GHIP
- FY18 Planning
- Next Steps

# Long Term Health Care Cost Projections for GHIP

# Long term health care cost projections

Long term cost projections reflect claims experience through June 2017 and approved program changes adopted for 7/1/2017, including vendor value-based care models (Aetna AIM and Highmark True Performance), enhanced Highmark clinical management program (CCMU), and utilization management through U.S. Imaging. The projected GHIP deficit has been reduced by **$133 million** over 5 years compared to prior estimates.



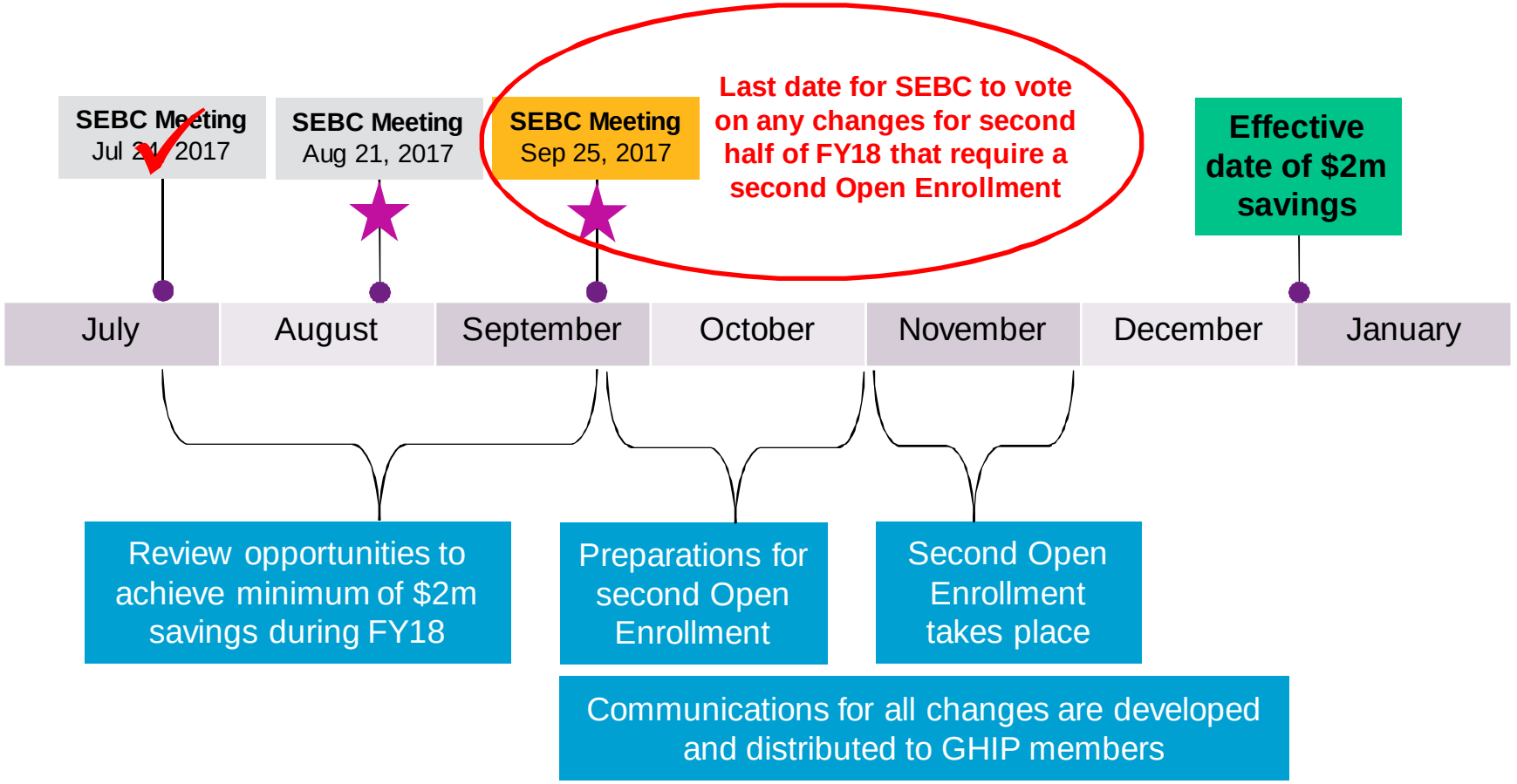

Note: FY18 budget projections assume no change to FY17 rates, and FY18 open enrollment elections as of June 2017. FY19 budget projections reflect GHIP claims experience through June 2017, reduction in EGWP direct subsidy payments effective 1/1/2018, and incremental savings from Year 3 of ESI contract. FY20 and beyond costs projected assuming 1% reduction in annual health care trend (from 6% to 5%) resulting from initiatives approved to date in FY18. Budget projections do not reflect any additional program changes.

# FY18 Planning

[redacted]

# Focal points for the SEBC – first half of FY18

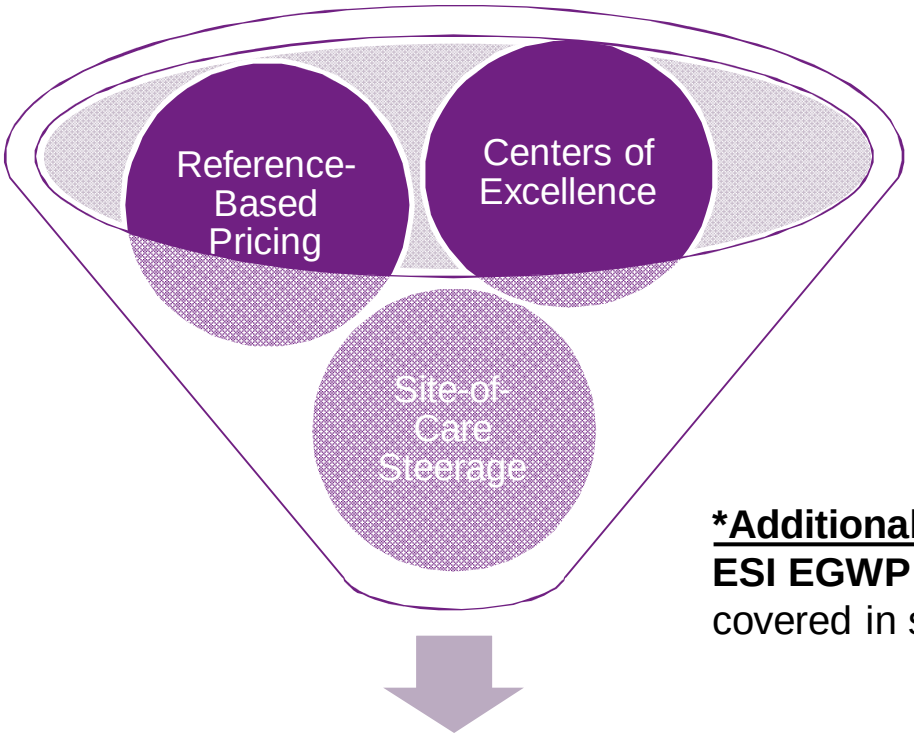
Timeline blueprint for tackling SEBC savings charge




Denotes opportunity for SEBC to vote on changes for second half of FY18

# FY18 SEBC charge: short-term opportunities

Short-Term Opportunities




***Additional Savings Opportunity: ESI EGWP Maintenance network**– covered in separate materials

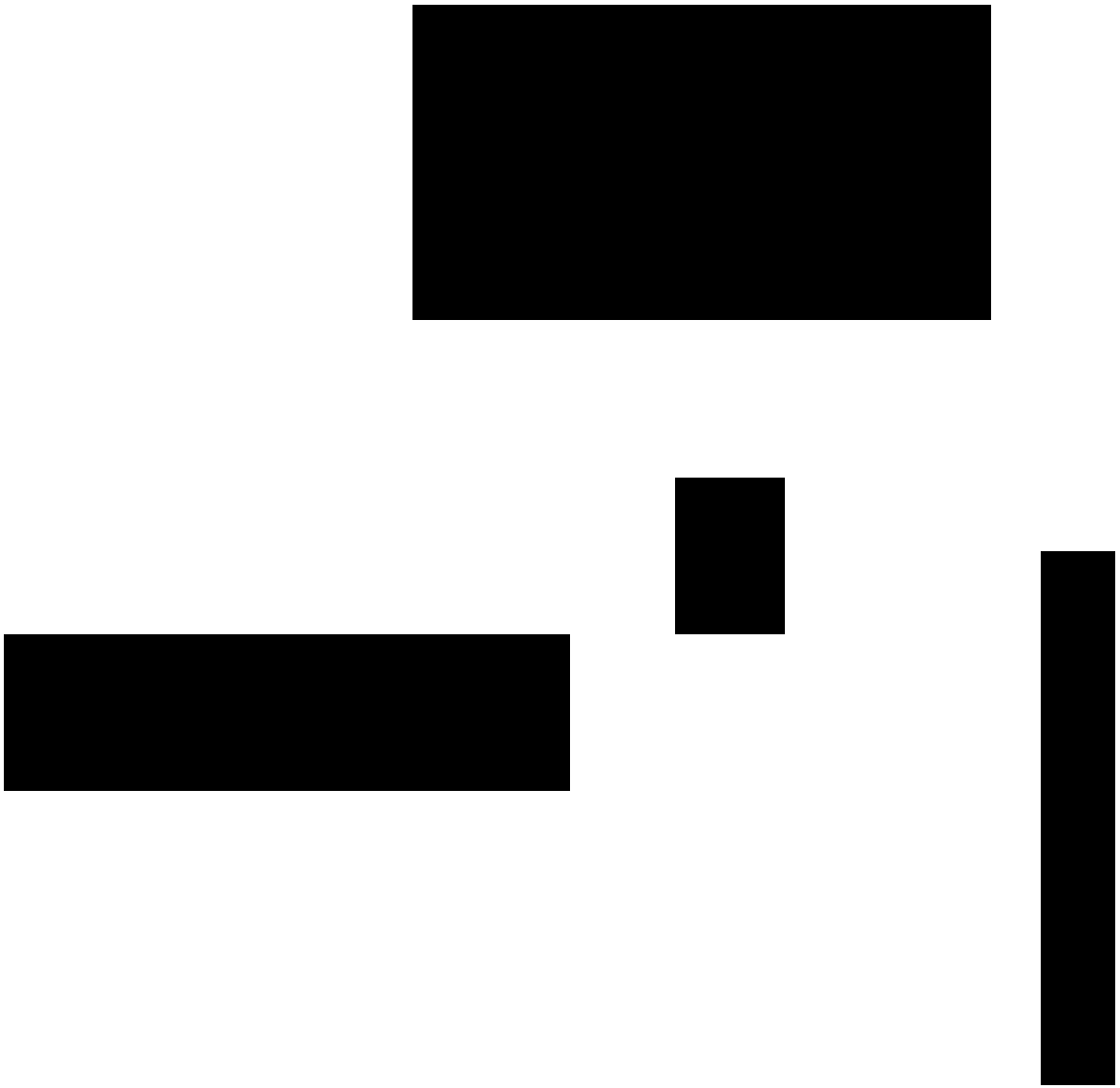
Evaluation Criteria

*Considerations for SEBC*

*General Fund Savings Potential*

*Member Experience/Impact*

# Site-of-Care Steerage



# Considerations for the SEBC

## Site-of-care steerage

***Topic Refresher:***

*Members pay lower out-of-pocket costs for using the most appropriate place of service for the care they need.*

- Both Aetna and Highmark administer site-of-care steerage for the State today for select services
- There are other types of services for which site-of-care steerage would be relevant:
  - Basic imaging services (e.g., X-rays, ultrasounds)
  - Outpatient lab services
  - **As a future state**: physician office visits (to physicians whose contracts with Aetna and Highmark include payment for performance, i.e., improved quality of services)
- Aetna and Highmark have observed changes in plan sponsors' utilization patterns as a result of implementing site-of-care steerage
  - Success is dependent on the impact of the cost share differential, member understanding of the benefit via communication, and the service(s) selected
    - Significant communication campaign (carrier and SBO) is encouraged to ensure member understanding of site-of-care steerage benefit
  - The State has successfully changed member behavior through implementing site-of-care steerage for high-tech imaging (i.e., MRI, CT scans) and urgent care
- There is no additional administrative cost associated with implementing additional design changes to promote site-of-care steerage

# Site-of-care steerage

## Estimated savings summary

| Carrier | Annual Claim Savings (%) | Annual Claim Savings ($) | Annual Claim Savings General Fund ($) | Claim Savings 2H FY18 General Fund ($) |
|---|---|---|---|---|
| Aetna | 0.35% | $0.5m | $0.3m | **$0.2m** |
| Highmark | 0.20% | $0.8m | $0.5m | **$0.3m** |

**Total FY18 Savings Opportunity: $0.5m**

- Modeling above assumes design changes are adopted to promote site-of-care steerage for basic imaging services, high-tech imaging services and outpatient lab services
  - As a potential future state consideration, steerage of physician office visits will help to drive members to higher quality providers
  - Consistent with existing site-of-care steerage design, modeling also assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
- Member disruption will vary based on procedure, education and specific provider
- *Note: additional savings can be realized through ESI EGWP Maintenance network (covered in separate materials)*

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels
Savings for active and pre-65 retiree populations only

# Aetna site-of-care steerage

## Estimated savings summary

| Type of service | HMO | | Annual Claim Savings[1] | |
|---|---|---|---|---|
| | Current | Proposed | (%) | ($) |
| Basic imaging services (e.g., X-rays, ultrasounds) | Outpatient facility: $20 copay | ▪ Outpatient facility, freestanding: $0 copay<br>▪ Outpatient facility, hospital-based: $35 copay | 0.05%[2] | $0.1m (<$0.1m general fund second half FY18) |
| High tech imaging services (e.g., MRI, CT scans) | ▪ Outpatient facility, freestanding: $0 copay<br>▪ Outpatient facility, hospital-based: $35 copay | ▪ Outpatient facility, freestanding: $0 copay<br>▪ Outpatient facility, hospital-based: $50 copay | 0.10% | $0.3m ($0.1m general fund second half FY18) |
| Outpatient lab services | Any lab: $10 copay | ▪ Preferred lab (Quest): $10 copay<br>▪ All other labs: $20 copay | 0.20% | $0.3m ($0.1m general fund second half FY18 |

**Total FY18 Savings Opportunity: $0.2m**

- Savings estimates assume that these changes are applicable to the HMO plan only
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and outpatient facility hospital-based to differentiate between basic imaging and high tech imaging

[1] Savings estimates based on assumed utilization; estimates provided on 8/16/2017. Savings for active and pre-65 retiree populations only.
[2] Aetna commented that basic imaging services yield <0.1% claims savings. 0.05% savings assumed.

# Highmark site-of-care steerage

## Estimated savings summary

| Type of service | Comprehensive PPO, In-network design | | Annual Claim Savings[1] | |
|---|---|---|---|---|
| | Current | Proposed | (%) | ($) |
| Basic imaging services (e.g., X-rays, ultrasounds) | Outpatient facility: $20 copay | ▪ Outpatient facility, freestanding: $0 copay<br>▪ Outpatient facility, hospital-based: $35 copay | 0.10% | $0.4m ($0.1m general fund second half FY18) |
| High tech imaging services (e.g., MRI, CT scans) | ▪ Outpatient facility, freestanding: $0 copay<br>▪ Outpatient facility, hospital-based: $35 copay | ▪ Outpatient facility, freestanding: $0 copay<br>▪ Outpatient facility, hospital-based: $50 copay | 0.05% | $0.2m ($0.1m general fund second half FY18 |
| Outpatient lab services | Any lab (LabCorp in DE[2]): $10 copay | ▪ Preferred lab (LabCorp in DE[2]): $10 copay<br>▪ All other labs: $20 copay | 0.05% | $0.2m ($0.1m general fund second half FY18 |

**Total FY18 Savings Opportunity: $0.3m**

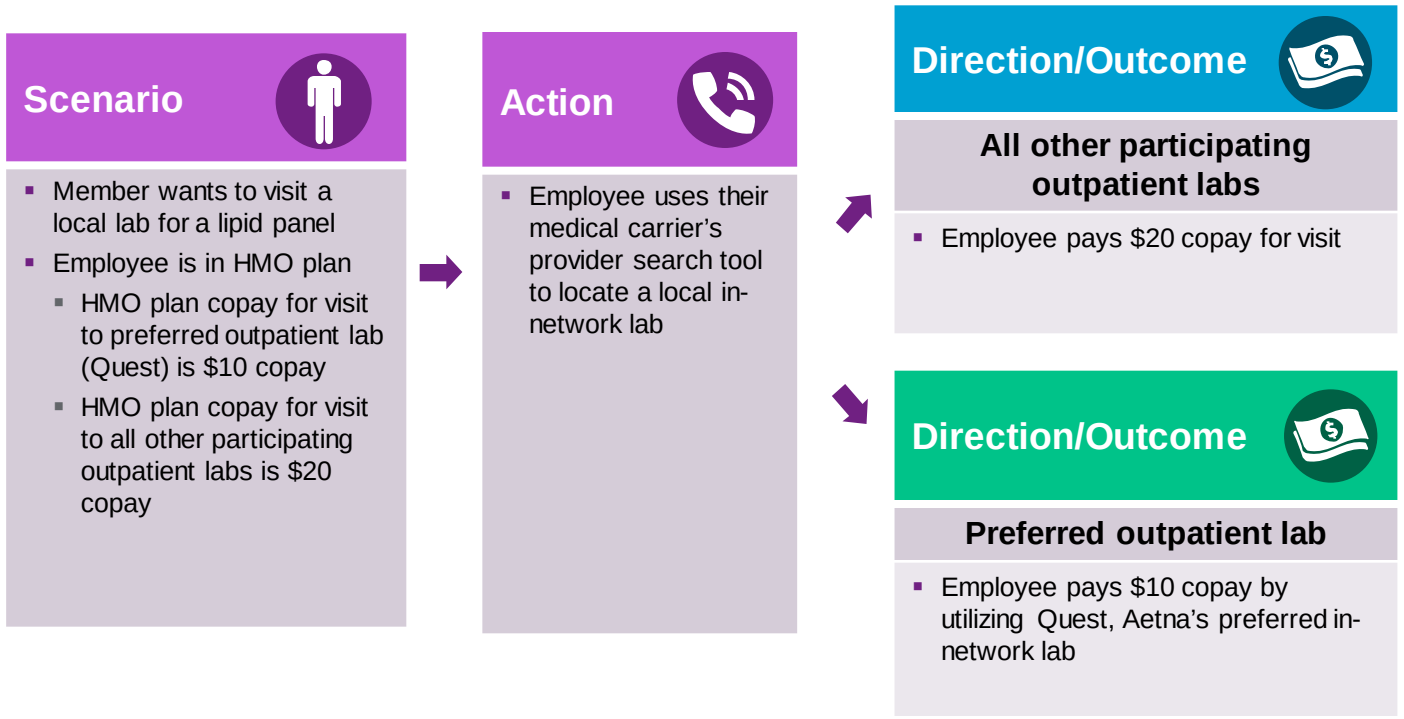
- Savings estimates assume that these changes are applicable to the in-network design provisions of the Comprehensive PPO plan only
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copy spread between freestanding and outpatient facility hospital-based to differentiate between basic imaging and high tech imaging

1. Savings estimates based on assumed utilization; estimates provided on 8/16/2017. Savings for active and pre-65 retiree populations only.
2. Other Blue plans outside of Delaware may contract with Quest and other independent labs for preferred pricing, the member would use the preferred freestanding in the state/network where they are receiving services.

# Site-of-care steerage

## Member impact – illustrative scenario *(assuming site-of-care steerage adopted)*

| HMO Plan – Outpatient Lab | |
|---|---|
| Current Provision | Proposed Provision (Illustrative) |
| ▪ $10 copay for any participating outpatient lab | ▪ $10 copay for preferred outpatient lab (Quest)<br>▪ $20 copay for all other participating outpatient labs |



# Centers of Excellence

[redacted]

# Centers of excellence

## Considerations for the SEBC

***Topic Refresher:***

*A Center of Excellence (COE) is a facility that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions. COEs may incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments). Plan design steerage to encourage use of COEs is optional.*

- Both Aetna and Highmark designate certain facilities within their provider networks as COEs
  - Today, the GHIP utilizes the COE network (and applicable benefit differential) for bariatric surgery and transplants
- Both vendors use similar criteria for determining the COE status of a facility
  - Facilities with COE designation differ between vendors
- Specific conditions/procedures applicable to COEs are typically elective and/or normally scheduled with the facility in advance (i.e., not for emergencies)
  - Aetna: cardiac – rhythm and surgery, orthopedic – spine and total joint replacements
  - Highmark: cardiac – coronary artery bypass graft surgery, heart valve surgery and angioplasty; knee/hip – joint replacements; spine – discectomy, fusion and decompression procedures
- Travel and lodging benefit is included for both Aetna and Highmark (i.e., for members living +100 miles away, reimbursement provided for patient and companion); however, some differences in benefit amounts exist between vendors

# Centers of excellence

## Estimated savings summary

| Carrier | Annual Claim Savings (%) | Annual Claim Savings ($) | Annual Claim Savings General Fund ($) | Claim Savings 2H FY18 General Fund ($) |
|---|---|---|---|---|
| Aetna | 0.90% | $1.4m | $0.9m | **$0.4m** |
| Highmark | 0.93% | $3.6m | $2.3m | **$1.2m** |

**Total FY18 Savings Opportunity: $1.6m**

- Modeling above assumes adoption of steerage to COEs for ALL applicable cardiac, knee/hip and spinal procedures
- Savings attributable to COE benefit design driven by plan design changes (increased member cost sharing at non-COE facilities) and improvements in quality associated with increased COE use
  - Roughly $0.9m of the $1.6m savings in FY18 attributable to plan design cost shifting, assuming that a portion of members use non-COE facilities despite the higher cost sharing—remaining savings ($0.7m) related to improved quality standards of COE-designation
  - Benefit differential will drive additional utilization of COE facilities, improving quality of care and reducing GHIP long term costs
- Member disruption will vary based on procedure, education and specific provider

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels
List of COE facilities (within 100 miles of DE) for Aetna and Highmark are located within the appendix on pages 37 and 38, respectively
Savings for active and pre-65 retiree populations only

# Aetna centers of excellence

## Estimated savings

| | Current | Proposed | Annual Claim Savings[1] | |
|---|---|---|---|---|
| | | | (%) | ($) |
| **Cardiac**<br>▪ Coronary artery bypass graft surgery<br>▪ Heart valve surgery<br>▪ Cardiac medical intervention (i.e. Angioplasty)<br>▪ Rhythm (pacemakers and ICD)<br>**Orthopedic/spine**<br>▪ Knee replacements<br>▪ Hip replacements<br>▪ Spine surgery | ▪ Inpatient Hospital, all facilities (in-network)<br>**CDH Gold**<br>Covered at 90%, after $1,500 deductible<br>**HMO**<br>Covered at 100%, after $100 per day copay for the first two days per confinement, and 100% no copay thereafter | ▪ Inpatient Hospital, **COE Facility** (in-network)<br>**CDH Gold**<br>Covered at 90% after $1,500 deductible<br>**HMO**<br>Covered at 100%, after $100 per day copay for the first two days per confinement, and 100% no copay thereafter<br>▪ Inpatient Hospital, **Non-COE Facility** (in-network)<br>**CDH Gold**<br>Covered at **75%** after $1,500 deductible<br>**HMO**<br>Covered at **75%** with no deductible and no copay | 0.90% | $1.4m ($0.4m general fund second half FY18) |

- Above designs create a meaningful spread between COE and non-COE facilities
- Services rendered at non-COE facilities were modeled at 75% coinsurance after the applicable deductible
  - Member coinsurance would accumulate towards total out-of-pocket maximum for cardiac and orthopedic procedures listed above, at COE and non-COE facilities

1. Estimates provided by Aetna on 7/26/2017. Savings for active and pre-65 retiree populations only.

# Highmark centers of excellence

## Estimated savings

| | Current | Proposed | Annual Claim Savings[1] | |
|---|---|---|---|---|
| | | | (%) | ($) |
| **Cardiac**<br>▪ Coronary artery bypass graft surgery<br>▪ Heart valve surgery<br>▪ Angioplasty<br><br>**Orthopedic**<br>▪ Knee replacements<br>▪ Hip replacements<br><br>**Spine**<br>▪ Discectomy<br>▪ Fusion<br>▪ Decompression | ▪ Inpatient Hospital, all facilities (in-network)<br>**Comprehensive PPO**<br>Covered at 100%, after $100 per day copay for the first two days per confinement, no deductible<br>**First State**<br>Covered at 90% for unlimited days, after $500 deductible[2]<br>**POS**<br>Covered at 90%, no deductible | ▪ Inpatient Hospital, **COE Facility** (in-network)<br>**Comprehensive PPO**<br>Covered at 100%, after $100 per day copay for the first two days per confinement, no deductible<br>**First State**<br>Covered at 90% for unlimited days, after $500 deductible[2]<br>**POS**<br>Covered at 90%, no deductible<br>▪ Inpatient Hospital, **Non-COE Facility** (in-network)<br>**Comprehensive PPO**<br>Covered at **75%**, after $100 per day copay for the first two days per confinement, no deductible<br>**First State**<br>Covered at **75%** for unlimited days, after $500 deductible[2]<br>**POS**<br>Covered at **75%**, no deductible | 0.93% | $3.6m ($1.2m general fund second half FY18) |

- Above designs create an meaningful spread between COE and non-COE facilities
- Services rendered at non-BDC facilities were estimated at 75% coinsurance after the applicable deductible
- The above includes estimated savings resulting from lower readmissions, higher quality of care, etc.

1. Estimates provided by Highmark on 8/7/2017. Savings for active and pre-65 retiree populations only.
2. Deductible shown for individual, family deductible $1,000
3. 75% coverage for Bariatric surgery performed at non-BDC facility does not accumulate towards the total out-of-pocket maximum as it is not an essential health benefit under the ACA

# Centers of excellence

## Member impact – illustrative scenario *(assuming COE differential adopted)*

| PPO Plan – Knee Replacement Surgery | |
|---|---|
| Current Provision | Revised Provision for additional COEs (Illustrative) |
| ▪ $100 per-day confinement copay (up to 2 days) | ▪ $100 per-day confinement copay for COE-designated facility<br>▪ $100 per-day confinement plus 25% coinsurance for non-COE-designated facility |

**Scenario**

- Member is covered by the Comprehensive PPO plan in EE Only coverage
- Member needs knee replacement surgery
- Primary care doctor recommends an orthopedic surgeon to perform the knee replacement
- Referral provided by primary care doctor is to a non-COE facility
- Example assumes $10,000 cost for surgery

**Action**

- Member calls health plan customer service to confirm whether surgeon and facility are in-network
- Member can also use their medical carrier's provider search tool to identify facilities within COE network
- Health plan customer service educates member on COE network benefits (both cost and quality)

**Direction**

**Non COE Facility**

- Member gets surgery at non-COE facility

**Outcome[1]**

**Non COE Facility**

- Member pays $200 copay plus $2,500 in coinsurance ($2,700 total)

**Direction**

**COE Facility**

- Member gets surgery at COE facility

**Outcome[1]**

**COE Facility**

- Member only pays $200 copay
- Because COE is used, additional benefits (to the member and the GHIP) include:
  - ✓ Surgery and post-operative care may be delivered more efficiently
  - ✓ Lower risk of complications and readmissions
  - ✓ Lower cost over time without sacrificing quality of care

1. Cost shown for illustrative purposes only and may vary based on provider and diagnosis.

# Reference-Based Pricing

[redacted]

# Reference-based pricing

## Considerations for the SEBC

***Topic Refresher:***

*Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, and health plan members must pay the difference in price if they select a more costly health care provider or service.*

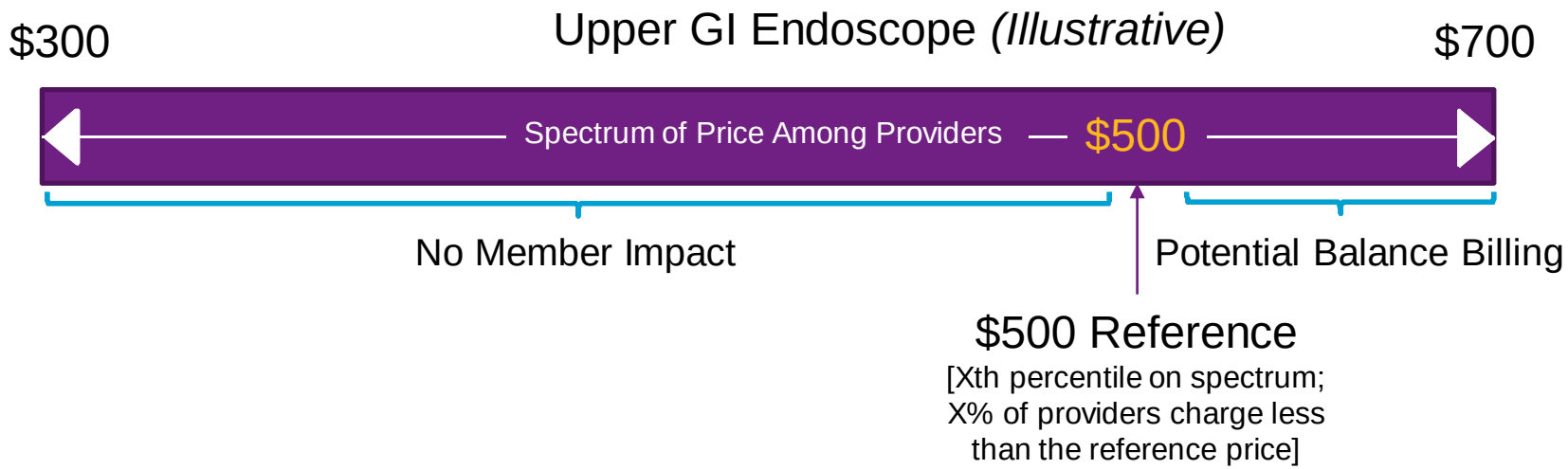
- Both Aetna and Highmark have capabilities to administer reference-based pricing (RBP)
- Program works best with coinsurance based plan designs (vast majority of the State's members are enrolled in the PPO and HMO plans, which are copay-based)
  - Members in a copay-based program are not currently exposed to differentials in underlying cost and would require intensive member education to move to reference-based pricing model
  - In a copay-based model, all billing occurs at point-of-care, while in coinsurance and reference-based models, members may receive a bill after the claim has been adjudicated
- Reference-based pricing differs slightly between Aetna and Highmark in terms of covered procedures, and network breadth (some network contracts stipulate provider may balance bill up to the contracted allowance, while others do not)
- Aetna and Highmark have limited data/analysis to conclude whether or not changes in member utilization patterns have occurred as a result of reference-based pricing being implemented
- In order for a reference-based pricing program to be successful, an intensive communication and member education program would need to be rolled out

| Vendor | Procedures Available[1] | Customers with RBP[2] | Program Administration Cost | Additional Considerations |
|---|---|---|---|---|
| Aetna | 6 Outpatient procedures<br>4 Outpatient imaging | 6 | None | Uses RBP bundles to group procedures |
| Highmark | 21 Outpatient procedures<br>7 Outpatient imaging | 1 | $0.50 PCPM | 6 month roll-out required |

[1] Full list available in appendix (pages 34 and 35)
[2] For Aetna and Highmark customers that have RBP in place today, a limited amount membership currently utilizes providers in Delaware (200 members for Aetna, none for Highmark)

# Reference-based pricing

## Mechanics of setting the reference price




- Reference price set at percentile of all provider charges
- The plan sponsor may set the reference price, in conjunction with the vendor partner, based on a sliding scale that has a correlation between savings and member impact
  - Higher percentile – less savings, less member impact
  - Lower percentile – more savings, more member impact
- The bulk of FY18 savings are generated by member cost shifting, and may also drive utilization to lower cost providers

# Reference-based pricing

## Estimated savings summary

| Carrier | Annual Claim Savings (%) | Annual Claim Savings ($) | Annual Claim Savings General Fund ($) | Claim Savings 2H FY18 General Fund ($) |
|---|---|---|---|---|
| Aetna | 1.31% | $2.0m | $1.3m | **$0.6m** |
| Highmark | 0.23% | $0.9m | $0.6m | **$0.3m** |

**Total FY18 Savings Opportunity: $0.9m**

- Modeling above assumes ALL procedures available for reference-based pricing are adopted
- Above modeling assumes Aetna reference set between 25th and 100th percentile (varies by procedure), and assumes Highmark reference set at 90th percentile
- Member disruption will vary based on procedure, education and specific provider utilized
  - Highmark cited that the potential average member liability can vary between $40 - $600 for outpatient imaging and $600 - $3,000 for outpatient procedures. Approximately 14% of outpatient imagining claims and 8% of outpatient procedure claims exceed the reference price
  - Aetna cited that for their available reference procedures, approximately 43% of the modeled claims exceed the reference price

**Highmark notes:**
Estimate provided by Highmark on 8/9/2017 based upon RBP modeling provided to the State of Delaware on March 7, 2016: Reference-Based Pricing overview presentation. 90% reference percentile utilized for modeling. The reference cost represents a percent of providers rendering the service at a cost at/or below a stipulated dollar level. Savings for active and pre-65 retiree populations only.
Savings noted above are net of $0.50 PCPM program fees

**Aetna notes:**
Estimates provided by Aetna on 8/15/2017. Aetna's reference price is set between the 25th and 100th percentile (varies by procedure) of allowed rates for the highest cost service that is frequently billed (i.e. represents at least 10% of the volume for that procedure group). The reference price is deterred for each geographic area and procedure group based on member access. Savings for active and pre-65 retiree populations only.

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels

# Reference-based pricing

## Member impact – illustrative scenario

| PPO Plan – Upper GI Endoscopy | |
|---|---|
| Current Provision | Revised Provision (Illustrative) |
| ▪ $30 copay at freestanding facility | ▪ Reference price set at $500 for procedure<br>▪ $30 copay, plus difference between billed charge and negotiated rate ($700) |

**Scenario**

- Employee needs a Upper GI endoscope
- Employee is in PPO plan
  - PPO plan copay for specialist visit is $30 at a freestanding facility
  - Under RBP, "reference price" for this procedure is $500

**Action**

- Employee uses their medical carrier's provider search tool to find a provider and look at their estimated cost (inclusive of the RBP estimate)
- Employee finds an in-network provider to have this procedure done

**Direction**

- Employee has GI endoscope at freestanding facility
- Negotiated rate for procedure at freestanding facility costs $700

**Outcome[1]**

**Today**

- Employee pays $30 copay for procedure
- State pays remainder of negotiated rate of $670 (or $700 - $30)
- No balance bill to employee

**Outcome[1]**

**With RBP**

- Employee pays $30 copay for procedure
- State pays $500 reference price under RBP
- **Employee receives balance bill for $200** (or $700 - $500)

- **Note:** the above is an illustrative scenario
- As previously noted, a copay-based program is not the ideal venue for adopting reference-based pricing

1. Cost shown for illustrative purposes only and may vary based on provider and diagnosis

# Next Steps

[redacted]

# Next steps

- Continuation of FY18 planning
- Items to discuss at 9/25 SEBC meeting:
  - Vote on potential savings opportunities for 1/1/2018:
    - Site-of-care steerage **($0.5m General Fund savings in second half FY18)**
    - Centers of excellence **($1.6m General Fund savings in second half FY18)**
    - Reference-based pricing **($0.9m General Fund savings in second half FY18)**
  - Begin to explore opportunities for FY2019 (7/1/2018 and beyond):
    - Active enrollment
    - Health savings accounts
    - Possibility of modification to the plan year to align with calendar year (i.e., 7/1 to 1/1)
    - Cost transparency
    - High performing providers
    - Plan design changes

# Appendix

# Tracking the progress: GHIP mission statement & core concepts

## GHIP Mission Statement and Core Concepts

**Progress review date:** August 21, 2017

***Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers***

**Core Concepts Benchmarking**

| Core Concept | Definition | Metric Benchmark Description | Benchmark | State of Delaware Metrics |
|---|---|---|---|---|
| **Adequate Access** | Access to various types of healthcare providers that meets generally accepted industry standards | Vendor-provided GeoAccess reporting indicating average distance to provider based on industry-standard access parameters | 1. Adequate network access ≥ 90%<br>2. 24% of employers offer ESHCs[1,3] | 1 Highmark/Aetna combined networks yield 99.86% access to in-network providers[2]<br>1 Highmark/Aetna combined networks yield 100% access to in-network PCPs<br>1 Highmark/Aetna combined networks yield 99.97% access to in-network specialists<br>2 Evaluated the ESHC[3] vendor marketplace |
| **High Quality Healthcare that Produces Good Outcomes** | Healthcare that meets nationally recognized standards of care established by various governmental and non-governmental health care organizations | Metrics as provided by GHIP's TPA which measure the effectiveness and quality of providers and care delivery within their given networks | 1. Robust Care Management Program offering for all EEs<br>2. High Performance Networks (HPNs)/Value Based Care[4]<br>a. 30% of employers have enhanced their care management offerings<br>b. 23% of employers use HPNs | 1 Highmark Custom Care Management Unit (CCMU) model implemented (FY2018)<br>1 Aetna Carelink enhanced care management program implemented (FY2018)<br>2 44% of Aetna network providers are in Value Based Care arrangements[5]<br>2 56% of Highmark network providers are in Value Based Care arrangements[6]<br>2 46% of State members are attributed to Delaware Value Based Care network providers[5]<br>2 54% of State members are attributed to Delaware Value Based Care network providers[6] |
| **Affordable Cost** | Healthcare cost trend is favorable compared to national and statewide trend, plans meet PPACA requirements, and program promotes greater fiscal certainty for the State | Participants: Plan actuarial value (AV) and affordability requirements under ACA<br>State: Annual trend rate for GHIP program | 1. Plan AV ≥ 60% and at least one plan's contributions are ≤ 9.5% of single employee household income<br>2. Market average medical trend at 6% for 2017<br>3. Programs that provide lower cost alternatives | 1 All of the GHIP's plans meet the 60% AV and 9.5% affordability metrics set forth under the ACA<br>2 GHIP medical trend projected at 5.3% for FY2017[7]<br>3 Hospital case rates have been implemented for select medical plans; reviewing other opportunities such as reference based pricing |

1. WTW 2016 Best Practices in Health Care Employer Survey
2. Based on FY2017 plan offerings for actives, pre 65 retirees and Medicare eligible retirees
3. ESHC: Employer Sponsored Health Center
4. WTW 2016 Emerging Trends in Health Care Survey - Education, Government and Public Sector (30 employers)
5. Based on metrics provided by Aetna on 8/8/2017
6. Based on metrics provided by Highmark on 8/8/2017
7. Based on 3Q2017 financial reporting; includes actives, pre-65 retirees and Medicare eligible retirees enrolled in the GHIP

Not yet started | On track | Completed

# Tracking the progress: GHIP mission statement & core concepts

## GHIP Mission Statement and Core Concepts

**Progress review date:** August 21, 2017

***Offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers***

**Core Concepts Benchmarking**

| Core Concept | Definition | Metric Benchmark Description | Benchmark | State of Delaware Metrics |
|---|---|---|---|---|
| **Healthy Lifestyles**<br>Additional utilization metrics will be tacked in a separate scorecard | Combination of behaviors that reduce health risk factors | Preventative care utilization metrics. Participation in wellness coaching, disease management, tobacco cessation, and other programs that encourage presentation and management of disease | 1. Preventative Care participation U.S. Norm[1]:<br>a. Cervical cancer screening 63.1%<br>b. Colon cancer screening 42%<br>c. Mammogram screening 67.4%<br>d. Cholesterol screening 79.9%<br>e. Physical exam participation 29.9%<br>2. Care Management participation exceeding vendor-provided book-of-business[2]:<br>a. 0.75% of unique MBRs targeted for outreach<br>b. 0.39% engaged cases<br>c. 18.4 % of MBRs Identified w DM Opportunity<br>d. 4.4% of MBRs w Nurse Engagement | **Selected Preventive care though December 2016[1]:**<br>1.a 67% of the applicable population enrolled received cervical cancer screening<br>1.b 40% of the population enrolled participated in colon cancer screening<br>1.c 58% of applicable GHIP members currently receive mammograms<br>1.d 36% of the population enrolled engaged in cholesterol screening<br>1.e 36% of the population enrolled completed a physical exam<br>1 FY2018 State of Delaware and DHHS cancer screening initiative<br>**Selected Care Management though December 2016[2]:**<br>2.a Aetna HMO: 0.07% of unique members targeted for outreach<br>2.b Aetna HMO: 0.02% engaged cases<br>2.c Aetna HMO 20.4% of MBRs Identified w DM Opportunity<br>2.d Aetna CDH Gold: 3.5% of MBRs w Nurse Engagement<br>2.b Highmark 8.1% engaged |
| **Engaged Consumers** | Members using all available resources provided by the State to make informed decisions on how, where and when they seek care | On-line consumerism class utilization and utilization of vendor provider lookup, quality, and transparency tools | 1. Ongoing member education on health care consumerism is provided | 1 54.5% of the overall GHIP employee population participated in the consumerism website course as of 4/3/2017<br>1 Over 50% employees enrolled through Employee Self Service, up from 20% in prior years as of 7/1/2017<br>1 Over 33% of the population enrolled in a consumer or value based plan (CDH & AIM HMO) as of 7/1/2017 |

Not yet started | On track | Completed

1. Based on FY2016 screening rates by all plans provided by Truven; 2016 U.S. Norm from Truven's commercial database
2. Based on 2Q2017 Aetna performance and Customer Experience Review and Highmark 3Q2017 Operations Dashboard. Statistics include Aetna BOB

# Tracking the progress: GHIP strategic framework goals

## Strategic Framework Scorecard

**Progress review date:** July 24, 2017

**Progress Evaluation - Tracking Against Goals**

| Goals | Progress | Timing | Steps Taken / Actions Planned |
|---|---|---|---|
| **Goal 1:** Addition of at least net 1 value-based care delivery (VBCD) model by end of **FY2018** |  |  | 1 Introduction of AIM HMO model via Aetna/CareLink partnership, effective 7/1/2017<br>2 Continue to work with Highmark and the State's other carriers to identify opportunities to implement other VBCD models |
| **Goal 2:** Reduction of gross GHIP medical and prescription drug trend by 2% by end of **FY2020** |  |  | 1 Adoption of cost reduction programs, i.e., CCMU, Diabetes Prevention Program, AIM HMO<br>2 Additional changes to promote use of high quality/efficient providers are under consideration |
| **Goal 3:** GHIP membership enrollment in a consumer-driven or value-based plan exceeding 25% of total population by end of **FY2022** |  |  | 1 5% of employees enrolled in the CDH Gold plan[1]<br>2 28% of employees enrolled in the Aetna HMO AIM Model[1]<br>3 Introduction of Health Savings Account, under consideration for 1/1/2019 |

Not yet started  On track  Completed

1. Based on enrollment reported in the FY2018 Budget (6/21/2017)

# Tracking the progress: GHIP savings projections

## Savings Projections

**Progress review date:** August 21, 2017

*Goals:*
- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

| Savings Projections | | | |
|---|---|---|---|
| **Initiative** | **Goals** | **Description** | **FY18 Savings** |
| Reduction of Administrative Fees through Medical TPA RFP[1] | ○ | The Medical TPA RFP resulted in reduced administrative fees for all plans and elimination of two plan options (Highmark HMO and Highmark CDH Gold) | **$1.5M** |
| Addition of Value-Based Care Models[2] | ■○▲ | Participation in vendor value-based care models, including Aetna (AIM) and Highmark (True Performance) will yield savings through risk sharing arrangements and better management of populations | **$1.6M** |
| Improved Consumerism as a Result of Decision Support[3] | ○▲ | Increasing decision support through education and marketing of health plan options may yield savings by making State employees better health care consumers | **$4.4M** |
| Enhanced Highmark Clinical Management Program[4] | ○ | Adoption of enhanced program for clinical management (CCMU) | **$5.5M - $7.4M** |
| Implementation of US Imaging[5] | ○ | Adoption of US Imaging high tech radiology utilization management program with Aetna | **$0.2M - $0.9M** |
| Change to Double State Share[6] (1/1/2018 implementation) | ○ | Employees and retirees who are married will pay 50% of the contribution for corresponding plan/coverage tier. Married employees/retirees will each pay 50% if electing separate coverage. | **$0.8M** |
| Diabetes Prevention Program (1/1/2018 implementation) | ○ | Structured lifestyle and health behavior change diabetes prevention program (DPP) with the goal of preventing the onset of diabetes in individuals who are pre-diabetic | **$0.2M [cost] - $0.7M [savings]** |
| | | **Total Savings:** | **$13.8M - $17.3M** |

1. Administrative Fees for FY18 exclude additional fees for value-based care models (AIM and True Performance). Savings reflects migration from Highmark HMO and Highmark CDH to other plan options
2. Savings net of risk sharing payments, Care Link and True Performance program fees.
3. Decision support savings are a high-level estimate, assuming 1% reduction in medical claim costs for Active population—these savings are not explicitly built into FY18 projections
4. Savings estimate based on Highmark FY18 plans only. Excludes savings for enhanced clinical management through Aetna AIM. Savings net of administrative fees
5. Savings estimate provided by US Imaging. Range reflects the degree to which current Highmark HMO/CDH enrollees migrate into Aetna plans for FY18 (i.e., 0% - 75% migration into Aetna plans), and assumes 25% of total Aetna-enrolled population uses the US Imaging program
6. Estimated savings would be a reduction to the State General Fund budget and not the GHIP

# Selected “Healthy Lifestyles” metrics

| Benchmark | State of Delaware Metrics |
|---|---|
| 1. Preventative Care participation U.S. Norm[5]:<br>a. Cervical cancer screening 63.1%<br>b. Colon Cancer screening 42%<br>c. Mammogram screening 67.4%<br>d. Cholesterol Screening 79.9%<br>e. Physical exam participation 29.9%<br>2. Care Management participation exceeding vendor-provided book-of-business[6]:<br>a. 0.75% of unique MBRs targeted for outreach<br>b. 0.39% engaged cases<br>c. 18.4 % of MBRs Identified w DM Opportunity<br>d. 4.4% of MBRs w Nurse Engagement | **Preventive care though December 2016[5]:**<br>1.a 67% of the applicable population enrolled received cervical cancer screening<br>1.b 40% of the population enrolled participated in colon cancer screening<br>1.c 58% of applicable GHIP members currently receive mammograms<br>1.d 36% of the population enrolled engaged in cholesterol screening<br>1.e 36% of the population enrolled completed a physical exam<br>1 FY2018 State of Delaware and DHHS cancer screening initiative<br>**Care Management though December 2016[6]:**<br>2.a Aetna HMO: 0.07% of unique members targeted for outreach<br>2.b Aetna HMO: 0.02% engaged cases<br>2.c Aetna HMO 20.4% of MBRs Identified w DM Opportunity<br>2.c Aetna CDH Gold 12.2% of MBRs Identified w DM Opportunity<br>2.d Aetna HMO: 3.3% of MBRs w Nurse Engagement<br>2.d Aetna CDH Gold: 3.5% of MBRs w Nurse Engagement<br>2.a Highmark 19.1% attempts<br>2.a Highmark 11.2% reached<br>2.d Highmark 8.1% engaged |

1. WTW 2016 Best Practices in Health Care Employer Survey
2. Based on FY2017 plan offerings for actives, pre 65 retirees and Medicare eligible retirees
3. ESHC: Employer Sponsored Health Center
4. Based on 3Q2017 financial reporting; includes actives, pre-65 retirees and Medicare eligible retirees enrolled in the GHIP
5. WTW 2016 Emerging Trends in Health Care Survey - Education, Government and Public Sector (30 employers)

# Opportunities for FY2018

**FY2018 Epilogue Language (Section 25):**

The State Employee Benefits Committee shall implement changes to be effective no later than January 1, 2018 which achieve a minimum savings of $2,000.0 [$2 million] during Fiscal Year 2018. These changes would include, but not be limited to, increasing member cost sharing through plan design changes which would include deductibles, copays, coinsurance in the active/non Medicare plans or Medicare plan for medical or prescription coverage; site of service steerage; centers of excellence and other high performing networks or providers; and tiered and/or reference based pricing.

# Opportunities for FY18 – prioritization

| Type of change | Opportunity | Ease of implementation | Earliest timeframe for completion | Comment |
|---|---|---|---|---|
| **Communications and member action** | Cost transparency | Easy | By 1/1/18 | *Focal point for FY19 planning (7/1/18 Opportunity)* |
| | High performing providers | Easy | By 1/1/18 | *Focal point for FY19 planning (7/1/18 Opportunity)* |
| **Plan changes without second open enrollment** | Site-of-service steerage | Easy / Moderate[1] | By 1/1/18 | *1/1/18 Opportunity* |
| | Reference-based pricing | Moderate | By 1/1/18[2] | *1/1/18 Opportunity* |
| | Centers of Excellence | Complex | By 1/1/18 | *1/1/18 Opportunity* |
| **Second open enrollment likely required** | Plan design changes | Moderate | By 1/1/18 | *Focal point for FY19 planning (7/1/18 Opportunity)* |

As discussed during 7/24 SEBC meeting, these items are focal points for SEBC FY18 charge

[1] Depending on the complexity of plan design offered.
[2] Aetna can administer RBP by 1/1/2018. Highmark can administer starting 7/1/2018 (6 month lead time needed)

# Reference-based pricing procedure capabilities

Aetna

| Outpatient Procedures | Outpatient Imaging |
|---|---|
| Colonoscopy (preventive and screening)<br>Upper GI Endoscopy<br>Carpal Tunnel Release<br>Cataract Removal<br>Tonsillectomy/Adeniodectomy<br>Inguinal Herniorrhaphy | CT Scan with Contrast<br>CT Scan without Contrast<br>MRI with Contrast<br>MRI without Contrast |

**Note:** Aetna has four “standard bundles” for reference-based pricing. These include, GI scope, Complex Radiology, GI Scopes and Complex Radiology and Comprehensive

# Reference-based pricing procedure capabilities

Highmark

| Outpatient Procedures | Outpatient Imaging |
|---|---|
| Cataract Removal<br>Knee arthroscopy with cartilage repair<br>ACL repair by arthroscopy<br>Upper GI endoscopy<br>Upper GI endoscopy with biopsy<br>Carpal tunnel<br>Shoulder arthroscopy<br>Shoulder arthroscopy with rotator cuff repair<br>Colposcopy with removal of lesion(s)<br>Colonoscopy with biopsy<br>Back surgery – laminectomy<br>Bladder repair for incontinence (sling)<br>Bunionectomy<br>Endoscopy – sinus surgery<br>Insertion of tubes in ears<br>Umbilical hernia repair – age 5+<br>Release trigger finger<br>Inguinal hernia repair – laproscopic<br>Inguinal hernia repair – age 5+ non laparoscopic<br>Esophagoscopy<br>Hammertoe correction | MRI<br>(includes Orbit/face/neck, brain, neck spine, lumbar spine, spine, arm joint, arm (other than joint), abdomen, pelvis, leg, leg with joint<br>Ultrasound of pelvis<br>Ultrasound of abdomen<br>CAT scan<br>(includes head/brain, mount/jaw/neck, angiography of head with and without contrast, abdomen, chest, pelvis, abdomen and pelvis, angiography of abdomen with and without contrast)<br>PET scan skull base to mid-thigh<br>PET scan image whole body |

# Aetna and Highmark COE criteria

- Aetna COE definition – facilities that have demonstrated high levels of quality and cost efficiency performing certain procedures
  - **Institutes of Quality** – Bariatric, Cardiac, Orthopedic (joint replacement and spinal surgery)
  - **Institutes of Excellence** – Transplants (organ and bone marrow), Infertility Treatment
- Highmark COE definition – facilities that deliver high-quality care and superior outcomes for high-risk, high-cost surgical procedures ("Blue Distinction Specialty Care" nationwide quality designation)
  - Specialty areas – Bariatric, Cancer (rare and complex), Cardiac, Maternity, Orthopedic – Knee & hip replacement, Orthopedic – Spinal surgery, Transplants
  - **Blue Distinction Centers (BDC)** – demonstrated quality care, treatment expertise and, overall, better patient results
  - **Blue Distinction Centers+ (BDC+)** – offer more affordable care in addition to having demonstrated quality care, treatment expertise, and, overall, better patient results

# Aetna COEs in Delaware and nearby states[1]

| | Within Delaware | Within nearby states (up to 100 mile radius) |
|---|---|---|
| **Cardiac** | None in Delaware | **Maryland**<br>Baltimore-area facilities – 5<br>Other Maryland facilities – 1<br>▪ Including: Peninsula Regional Medical Center – Salisbury, MD<br><br>**New Jersey**<br>Northern-area facilities – 1<br>Other New Jersey facilities – 1<br><br>**Pennsylvania**<br>Philadelphia/Southern NJ-area facilities – 1<br>Other Pennsylvania facilities – 5<br><br>**Washington, D.C.**<br>D.C. and surrounding areas – 2 |
| **Orthopedic / Spine** | **Christiana Care –** Wilmington, DE | **Maryland**<br>Baltimore-area facilities – 9<br>Other Maryland facilities – 0<br><br>**New Jersey**<br>Northern-area facilities – 0<br>Other New Jersey facilities – 0<br><br>**Pennsylvania**<br>Philadelphia/Southern NJ-area facilities – 8<br>Other Pennsylvania facilities – 7<br><br>**Washington, D.C.**<br>D.C. and surrounding areas – 4 |

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

# Highmark COEs in Delaware and nearby states[1]

| | Within Delaware | Within nearby states (up to 100 mile radius) |
|---|---|---|
| **Cardiac** | **Bayhealth Hospital** – Dover DE<br>**Beebe Medical Center** – Lewes, DE<br>**Christiana Care –** Newark, DE | **Maryland**<br>Baltimore-area facilities – 1<br>Other Maryland facilities – 1<br>• Peninsula Regional Medical Center – Salisbury, MD<br>**Pennsylvania**<br>Philadelphia-area facilities – 7<br>Other PA facilities – 15<br>**Washington, D.C.**<br>D.C. and surrounding area – 3 |
| **Orthopedic** | None in Delaware | **Maryland**<br>Baltimore-area facilities – 11<br>Other Maryland facilities – 7<br>• Including: Peninsula Regional Medical Center – Salisbury, MD<br>**Pennsylvania**<br>Philadelphia-area facilities – 13 (including 2 in Southern NJ)<br>Other PA facilities – 17<br>**New Jersey**<br>Other NJ facilities – 2<br>**Washington, D.C.**<br>D.C. and surrounding area – 6 |
| **Spine** | **Beebe Medical Center** – Lewes, DE<br>**Christiana Care –** Newark, DE | **Maryland**<br>Baltimore-area facilities – 8<br>Other Maryland facilities – 4<br>• Including: Peninsula Regional Medical Center – Salisbury, MD<br>**Pennsylvania**<br>Philadelphia-area facilities – 9 (including 1 in Southern NJ)<br>Other PA facilities – 10<br>**Washington, D.C.**<br>D.C. and surrounding area – 4 |

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.